TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SAMUEL J ALIANELL MD

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE COMPANY

MFDR Tracking Number
M4-18-0563-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
November 1, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The charges referenced herein were filed with the Carrier and paid. The Carrier then requested a refund based on 'Services not authorized by claims specialist, pay direction code has note that ongoing UDS should not be paid'. An appeal was sent to the Carrier along with a non-related MFDR decision as reference to support that preauthorization was not required. The appeal was denied by a copy of a fax from Patricia Matushak stating 'I have moved your appeal to be reviewed by the case manager and they stated that the appeal has been reviewed, but that appeal wouldn't change the amount of the refund request, refund stands'... We believe these services did not need preauthorization as indicated in the refund request... As such, we respectfully request medical fee dispute resolution."

Amount in Dispute: $1,321.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is not a network claim. The bill has been reviewed and denial stands as Peer review indicates 'since ther [sic] is no indication for ongoing use of medication, there is no indication for ongoing drug screes'. Peer Review is attached for your review."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 23, 2017	G0482	$1,021.70	$255.43
June 20, 2017	80307	$300.00	$76.28
TOTAL		$1,321.70	$331.71

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §133.260 sets out the refund guidelines.
4. EOB dated July 31, 2017 for date of service May 23, 2017:
   - Z710 – The charge for this procedure exceeds the fee schedule allowance.
   - P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - PLAB – The reimbursement is based on the CMS clinical lab fee schedule

   EOB dated July 25, 2017 for date of service June 20, 2017:
   - Z710 – The charge for this procedure exceeds the fee schedule allowance.
   - P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - PLAB – The reimbursement is based on the CMS clinical lab fee schedule

Issues

1. Did the insurance carrier request a refund within the time allowed per 28 Texas Administrative Code §133.260(a)?
2. Did the insurance carrier submit the refund request to the health care provider in an explanation of benefits in the form and manner prescribed by the Division?
3. Did the requestor respond to the request for a refund from the insurance carrier?
4. Did the insurance carrier meet the requirements of 28 Texas Administrative Code 133.260(d)?
5. Did the requestor remit the refund with any applicable interest within 45 days of receipt of notice of denied appeal prior to the filing of MFDR?
6. Did the requestor meet the requirements of 28 Texas Administrative Code §134.203(b)?
7. Are the insurance carrier's reasons for a refund request supported?
8. What is the rule that applies to reimbursement?
9. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.260(a) states in pertinent part "An insurance carrier shall request a refund with 240 days from the date of service or 30 days from completion of an audit performed in accordance with §133.230 (relating to Insurance Carrier audit of a Medical Bill), whichever is later, when it determines that inappropriate health care was previously reimbursed, or when an overpayment was made for health care provided"

   The requestor seeks resolution of an insurance carrier refund request for services rendered on May 23, 2017 and June 20, 2017. On August 8, 2017 the insurance carrier requested a refund from the requestor for CPT Codes 80307 and G0482 in the amount of $480.97 the amount previously reimbursed to the requestor. The division finds that the insurance carrier meet the requirements of 28 Texas Administrative Code 133.260(a).

2. Per 28 Texas Administrative Code 133.260 (b) "The insurance carrier shall submit the refund request to the health care provider in an explanation of benefits in the form and manner prescribed by the Division. (c) A health care provider shall respond to a request for a refund from an insurance carrier by the 45th day after receipt of the request by: (1) paying the requested amount; or (2) submitting an appeal to the insurance carrier with a specific explanation of the reason the health care provider has failed to remit payment."

   Review of the insurance request letter dated August 8, 2017 is not in the form of an explanation of benefits. As a result, the insurance carrier did not meet the requirements of 28 Texas Administrative Code 133.260 (b).

3. Per 28 Texas Administrative Code §133.260 (c) A health care provider shall respond to a request for a refund from an insurance carrier by the 45th day after receipt of the request by: (1) paying the requested amount; or (2) submitting an appeal to the insurance carrier with a specific explanation of the reason the health care provider has failed to remit payment.

   The requestor responded to the refund request on September 1, 2017 stating in pertinent part, "This reason 'Services not authorized by Claims Specialist' is inappropriate. Claims should be processed in accordance with Texas Administrative Code Rules, not denied per a Claims Specialist... UDT is not listed in subsections (p) or (q) of TAC Rule §134.600 (c) and do not require preauthorization." The division finds that the requestor meet the requirements of 28 Texas Administrative

Code 133.260(b)(2) as the carrier made the request on August 8, 2017 and the requestor made the appeal on September 1, 2017 within the 45 days as required by Rule 133.260(b)(2). The requestor therefore meet the requirements of 28 Texas Administrative Code §133.260 (c).

4. Per 28 Texas Administrative Code 133.260(d) "The insurance carrier shall act on a health care provider's appeal within 45 days after the date on which the health care provider filed the appeal. The insurance carrier shall provide the health care provider with notice of its determination, either agreeing that no refund is due, or denying the appeal."

   The insurance carrier acted on the health care provider's appeal on October 20, 2017 via e-mail correspondence. The division finds that the insurance carrier meet the 45-day timeframe requirement of §133.260(d).

5. Per 28 Texas Administrative Code 133.260(e) "If the insurance carrier denies the appeal, the health provider:
   (1) Shall remit the refund with any applicable interest with 45 days of receipt of notice of denied appeal; **and**
   (2) May request medical dispute resolution in accordance with §133.305 of this chapter (relating to Medical Dispute Resolution – General)."

   In this case, the requestor received notice of the denial of the appeal on October 20, 2017. The requestor submitted a copy of a check dated October 25, 2017 issued to Liberty Mutual Insurance in the amount of $480.87. The requestor submitted sufficient documentation to support that the refund was remitted to the insurance carrier after the denial of the appeal and before the submission of the medical fee dispute. The division finds that the refund dispute request for medical fee dispute resolution was submitted in accordance with 28 Texas Administrative Code 133.260(e). As a result, the Division will review the disputed services and determine if the insurance carrier is entitled to the refund made by the requestor.

6. The requestor seeks reimbursement for CPT Code 80307 rendered on June 20, 2017 and G0482 rendered on May 23, 2017 and previously paid by the insurance carrier. The requestor remitted the refund to the insurance carrier prior to the filing of the medical fee dispute request. The Division will now determine if the requestor is entitled to the monies refunded to the insurance carrier.

   The insurance carrier requested a refund on August 8, 2017 stating in pertinent part, "This overpayment occurred because Incorrect Payments – Services not authorized by Claims Specialist. Pay Direction Code has note that ongoing UDS should not be paid [diagnosis codes]."

   28 Texas Administrative Code §134.203 states in pertinent part, "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers."

   Review of the submitted medical bill documents that the following CPT Code was billed on May 23, 2017:

   - G0482 - Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class(es), including metabolite(s) if performed.

   Review of the submitted medical bill documents that the following HCPCS Code was billed on June 20, 2017:

   - 80307 – Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service.

   Review of CHAPTER 10 for CPT codes 80000-89999 found at:
   https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html states the following:

   Beginning January 1, 2017, urine drug presumptive testing may be reported with CPT codes 80305-80307. These codes differ based on the level of complexity of the testing methodology. Only one code from this code range may be reported per date of service.

Beginning January 1, 2016, urine drug definitive testing may be reported with HCPCS codes G0480-G0483. These codes differ based on the number of drug classes including metabolites tested. Only one code from this code range may be reported per date of service.

Per Chapter 10 of the Medicare manuals, CPT Code 80307 differs from the HCPCS Codes G0482 and is not all-inclusive nor is there a CCI edit that exists between the two codes. The service in dispute will be reviewed per applicable fee guidelines.

7. The requestor seeks reimbursement for drug testing codes, G0482 and 80307. The insurance carrier's reason for the refund request, states in pertinent part, "Services not authorized by Claims Specialist."

   28 Texas Administrative Code §134.600(p)(12) states in pertinent part "(p) Non-emergency health care requiring preauthorization includes: (12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits)."

   28 Texas Administrative Code (TAC) §137.100 (a) states, in pertinent part, "Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp..."* Health care provided in accordance with the Division treatment guidelines is presumed reasonable as specified in Labor Code §413.017, and is also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a).

   Review of the 2017 ODG pain chapter under "Drug testing" finds that drug testing is recommended. The division concludes that the services were provided in accordance with the division's treatment guidelines; that the services are presumed reasonable pursuant to 28 TAC §137.100(c), and Labor Code §413.017; and are also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a).

   For the reasons stated above the Division finds that insurance carrier's refund request is not supported and therefore the requestor is entitled to reimbursement for the disputed services.

8. 28 Texas Administrative Code 134.203 (e) states in pertinent part, "The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and, (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service.

   Procedure code G0482 rendered on May 23, 2017, represents a lab service paid per 28 Texas Administrative Code §134.203(e). The Medicare Clinical Lab Fee is $204.34 x 125% of this amount is $255.43. There is not a professional component therefore the Maximum Allowable Reimbursement is $255.43. This amount is recommended

   Procedure code 80307, June 20, 2017, represents a lab service paid per Rule §134.203(e). The Medicare Clinical Lab Fee is $61.02 x 125% of this amount is $76.28. There is not a professional component therefore the Maximum Allowable Reimbursement is $76.28. This amount is recommended.

   The requestor submitted a refund amount of $480.97 for the disputed services indicated above. Review of the EOBs indicate that the insurance carrier issued payments above the fee guideline, no documentation was submitted to the division to support why the requestor was reimbursed above the fee guidelines. The requestor is therefore entitled to the MAR reimbursement in the amount of $331.71. Therefore this amount is recommended.

9. The Division therefore finds that the requestor is entitled to reimbursement in the amount of $331.71, therefore this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $331.71.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $331.71 reimbursement for the disputed services.

Authorized Signature

_____	_ _____	November 17, 2017_____
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.